



CANNON BUILDING
861 SILVER LAKE BLVD., SUITE 203
DOVER, DELAWARE 19904-2467

STATE OF DELAWARE
DEPARTMENT OF STATE
DIVISION OF PROFESSIONAL REGULATION
BOARD OF NURSING

TELEPHONE: (302) 744-4500
FAX: (302) 739-2712
WEBSITE: DPR.DELAWARE.GOV

APPLICATION FOR REINSTATEMENT OR LICENSURE AS AN RN OR LPN INSTRUCTION SHEET

Please read all instructions carefully before completing and submitting your application. Failure to follow instructions may result in a delay of licensure.

When to File Reinstatement Application

Complete and submit this application only if you previously held a Delaware Nursing license of the same type and either

- meet the practice requirement, or
- have completed a *Board-approved* refresher program

See Section 6.6 of the Rules and Regulations, available on dpr.delaware.gov.

If you are *currently* licensed in another state that is a nurse licensure compact state (listed below), file this application *only if* you

- are moving from a compact state to a non-compact state, and
- want to practice in Delaware.

COMPACT STATES

Arizona, Arkansas, Colorado, Delaware, Idaho, Iowa, Kentucky, Maine, Maryland, Mississippi, Nebraska, New Hampshire, New Mexico, North Carolina, North Dakota, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, Wisconsin

How to File Application

- ☐ Submit completed, signed and notarized application form.
 - If your name has changed since you were previously licensed in Delaware, enclose a copy of a legal document changing your name (e.g., marriage certificate, divorce decree).
 - Make sure all questions are answered unless the instructions tell you to skip a question.
 - Read the AFFIDAVIT section.
 - Sign the application in front of a notary public.
 - Forms that are incomplete, unsigned or not notarized will be rejected.
- ☐ Enclose processing fee of \$146 by check or money order made payable to "State of Delaware."
 - Applications submitted without this processing fee will be rejected.
- ☐ Attach a copy of your driver's license or official identification card from the Division of Motor Vehicles.
- ☐ If you are currently licensed in another state or jurisdiction, attach a photocopy of *each current* nursing license.
 - License must show an expiration date.
 - If there is a signature section on your license, sign it before copying.

- ☐ Complete the *Authorization for Release of Information* form to request a criminal background check. Follow the instructions on the authorization form to arrange to be fingerprinted. You must complete this requirement *even if* you recently had a criminal background check done for some other reason.
- ☐ Complete the applicant section of the *Employer Reference Form* and send to your nursing employer(s) during the most recent six months of your nursing practice.
 - After completing the form, the employer(s) must return the form directly to the Board office. Forms received from you will be rejected.
 - If it is your employer's policy not to comment on performance, submit a copy of your most recent employee evaluation to the Board office. Obtain this evaluation yourself; do not ask your employer to forward a copy.
- ☐ Complete the *Verification of Continuing Education* form following the instructions on the form.
 - Enter all courses/programs you have completed over the past two years.
 - RN's are required to complete 30 contact hours. LPN's are required to complete 24 contact hours.
- ☐ Enclose certificates of completion for the courses/programs you list on the *Verification of Continuing Education* form.
 - If you do not submit a completion certificate, no credit will be awarded for the course/program.

Applying for a Temporary Permit

Apply for a Temporary Permit *only if* you have an offer of employment and plan to start employment in Delaware before the reinstatement process is completed (4-6 weeks).

- ☐ Complete TEMPORARY PERMIT section of the application
 - **Do not begin orientation or employment until you are assigned a temporary permit number.**
 - If you are also applying for an APN license and need an APN Temporary Permit, apply *only* for the APN Temporary; do not complete the Temporary Permit section of the *Reinstatement* application.
- ☐ Enclose temporary permit fee of \$32.00 by check or money order made payable to "State of Delaware."
 - This fee is *in addition to* the processing fee for the application.
 - There is no additional fee for a permit extension.
- ☐ Effective January 1, 2009, the Board office must receive *results* of the criminal background check before issuing a temporary permit.

The temporary permit is issued for 90 days and may be extended.



OFFICE USE ONLY	
DDB #1 _____	DDB #2 _____
R _____	CBC _____
CCL EXPIRES _____	CE _____

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**APPLICATION FOR LICENSURE AS A REGISTERED NURSE OR PRACTICAL NURSE
BY REINSTATEMENT**

TYPE OF APPLICATION

1. Enter type and number of Delaware license you wish to reinstate:

- ☐ Registered Nurse - License Number: **L1**-_____ Issue Date: _____
☐ Licensed Practical Nurse – License Number: **L2**-_____ Issue Date: _____
☐ **Temporary Permit – I have an offer of Nursing employment in Delaware and wish to start working before the reinstatement process is completed.**

IDENTIFYING AND CONTACT INFORMATION

2. Full Name: _____
Last First Middle Maiden

3. Other Names Used: _____

If your name was different when you held a Delaware license, enter that name here and submit a legal document showing the name change (e.g., marriage certificate, divorce decree).

4. Address: _____

City State Zip

5. Enter your *State or Jurisdiction of Primary Residence*: _____ **Attach a copy of your driver's license or an identification card issued by the Division of Motor Vehicles showing this state or jurisdiction as your residence.**

6. Phone: _____
daytime evening or cell

7. Email: _____

8. Date of Birth (month/day/year): _____

9. Have you been issued a U.S. Social Security Number? Yes ☐ No ☐

- If yes, enter your SSN: _____
- If no, you must file a *Request for Exemption from Social Security Number Requirement*.

LICENSURE HISTORY – In these questions, jurisdiction means State, District of Columbia, U.S. territory or other country.

10. Have you ever been denied Nursing licensure in Delaware or other jurisdiction? Yes ☐ No ☐ If yes, where? _____ **Attach a copy of the legal documents.**

11. List all states and jurisdictions where you have *ever* held a Nursing license. If you need more room, attach a separate sheet following this format:

RN or LPN?	JURISDICTION (state, territory, or other country)	LICENSE NUMBER	EXPIRATION DATE	CURRENT STATUS OF LICENSE
RN <input type="checkbox"/> LPN <input type="checkbox"/>				
RN <input type="checkbox"/> LPN <input type="checkbox"/>				
RN <input type="checkbox"/> LPN <input type="checkbox"/>				

Attach copy of each *current* Nursing license you now hold.

12. Are any of your Nursing licenses currently under investigation? Yes ☐ No ☐ If yes, where? _____
Attach a copy of the legal documents.

13. Have any of your Nursing licenses been surrendered, revoked, suspended, limited or placed on probation? Yes ☐ No ☐ If yes, where? _____
Attach a copy of the legal documents.

DISCLOSURES

14. Have you ever been convicted of or entered a plea of guilty or *nolo contendere* (no contest) to any felony, misdemeanor or any other criminal offense, including any offense for which you have received a pardon, in any jurisdiction? Yes ☐ No ☐ If yes, explain: _____

15. Are you now, or have you *ever* been, dependent on the use of alcohol, stimulants, or habit-forming drugs? Yes ☐ No ☐ If yes, explain: _____

NURSING PRACTICE

16. Enter the following information about your **Nursing** employment for the past **five** years. Attach additional sheet if needed.

DATES (m/yr – m/yr)	RN or LPN?	EMPLOYER	ADDRESS (street, city, state)
	RN <input type="checkbox"/> LPN <input type="checkbox"/>		
	RN <input type="checkbox"/> LPN <input type="checkbox"/>		
	RN <input type="checkbox"/> LPN <input type="checkbox"/>		

17. Which of the following describes your Nursing practice? Check all that apply.

- ☐ I have practiced Nursing AT LEAST 1000 hours during the past five years.
☐ I have practiced Nursing AT LEAST 400 hours during the past two years.
☐ I have completed a Refresher Course in the past two years. **Submit proof of course completion.**
☐ I graduated from a Board of Nursing approved Nursing education program within the past two years.
☐ None of the above describes my practice. **Attach a written explanation.**

TEMPORARY LICENSURE – Complete this section *only if* you have an offer of employment and plan to begin work before the endorsement process is completed.

18. Enter the following information about your employment:

Employer: _____

Address: _____

_____ City _____ State _____ Zip

Contact Name: _____ Employer Phone: _____

Anticipated Start Date: _____

The Board office must also receive the temporary license fee, copy of your current Nursing license and results of the criminal background check before issuing a temporary permit.

If Board review of your application is required, the Board office must receive all of these items no later than 4:30 PM ten full working days before the Board's meeting date in order to assure consideration of your application at the meeting:

- Completed, signed and notarized application form
- Fee payment
- All required supporting documentation.

Applications that are not complete within six (6) months of filing may be considered abandoned and discarded. The Board office will attempt to notify you before disposing of an abandoned application.

Please note: When your application is complete, please allow 4-8 weeks to receive your permanent license (whether or not a temporary license has been issued).

AFFIDAVIT

The law regulating the practice of Nursing in Delaware, 24 Del. C. §1922 (a), "Grounds for Discipline," provides that the Board of Nursing may revoke or suspend any license to practice nursing, refuse a license or re-licensing or otherwise discipline a licensee upon proof that a licensee or former licensee is guilty of fraud or deceit in procuring or attempting to procure a license to practice nursing.

The applicant, being duly sworn, says that he/she is the person referred to in the foregoing application for licensure as registered/licensed practical nurse in the State of Delaware, that he/she meets the requirements for licensure, that the statements therein contained are true and that he/she has read and understands this affidavit.

APPLICANT SIGNATURE: _____ **DATE:** _____

Sworn to before me and subscribed in my presence this _____ day of _____ 2_____,
County of _____ State of _____

My commission expires: _____

Notary Public

SEAL

APPLICATIONS THAT ARE UNSIGNED, NOT NOTARIZED, INCOMPLETE OR SUBMITTED WITHOUT THE REQUIRED PROCESSING FEE WILL BE REJECTED.

Instructions for Requesting a Criminal Background Check

Criminal background checks, both federal and state, are required for all applicants for Nursing licensure. **You must complete this requirement *even if* you recently had a criminal background check done for some other reason.**

Locations

Kent County – Primary Facility

State Bureau of Identification
Blue Hen Mall & Corporate Center
655 Bay Rd. Suite 1B
Dover, DE 19901

Walk-ins accepted: Mon 9 am – 7 pm, Tue - Fri 9 am – 3 pm

Customer Service: (302) 672-5319

New Castle County - Satellite Facility

State Police Troop Two
100 LaGrange Ave
Newark, DE 19702
(Between Rts. 72 and 896 on Rt. 40)
By appointment only
Scheduling: (302) 739-2528 (local)
(800) 464-4357 (toll free)

Sussex County – Satellite Facility

Delaware State Police Troop Four
South DuPont Hwy & Shortley Rd.
Georgetown DE 19947
(Across from DelDOT & the State Service Ctr.)
By appointment only
Scheduling: (302) 739-2528 (local)
(800) 464-4357 (toll free)

Applicants Residing in Delaware

1. If you are using the New Castle or Sussex Counties locations, call **(800) 464-HELP (4357)** to schedule an appointment. No appointments are needed at the Kent County location.
2. Take the completed *Authorization for Release of Information* form to one of the offices listed above with the fee of \$69.00 to cover both the State and Federal criminal checks. As fees are subject to change, contact the agency where you plan to submit your forms for current fees. Cash, money orders and credit cards other than American Express are accepted. *Personal checks are not accepted.*

Out-of-State Applicants

1. You can be fingerprinted by your local police agency. All types of fingerprint cards are accepted. If your local police agency cannot provide a fingerprint card, call **(302) 672-5319** to request a fingerprint card.
2. Send your *Authorization for Release of Information* form, fingerprint card, and \$69.00 fee (by personal check or money order) to:

Delaware State Police
State Bureau of Identification (SBI)
PO Box 430
Dover, DE 19903-0430

⇒ **Allow four weeks for receipt of results.**

DO NOT SEND THE FORM OR FEE TO THE BOARD OF NURSING OFFICE!!



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**AUTHORIZATION FOR RELEASE OF INFORMATION
CRIMINAL HISTORY RECORD CHECK**

PRINT OR TYPE ALL INFORMATION IN BLACK INK.

REASON FOR REQUEST: Delaware Board of Nursing - License Application

LAST NAME FIRST NAME MI SUFFIX

ALL OTHER NAMES USED IN THE PAST:

1. _____
2. _____
3. _____
4. _____

MAIL THE RESULTS OF MY CRIMINAL HISTORY REQUEST TO THE ADDRESS I HAVE DESIGNATED BELOW:

Name/Company: Delaware Board of Nursing
Address: 861 Silver Lake Boulevard, Suite 203
City/State: Dover, DE 19904
ATTN: D. Mangler

AUTHORIZATION TO RELEASE INFORMATION:

As an applicant, I authorize release of any and all information that you have concerning me, including **CRIMINAL HISTORY RECORD INFORMATION** and other information of a confidential or privileged nature. I hereby release you, your organization, the State of Delaware and others from any liability or damage which may result from furnishing this information:

SIGNATURE OF PERSON PRINTED: _____ **DATE:** _____

Phone Number Home: _____ Work: _____

USE OF CRIMINAL HISTORY RECORD INFORMATION IS RESTRICTED BY LAW AND SHALL BE LIMITED TO THE PURPOSE FOR WHICH IT WAS GIVEN. MISUSE CONSTITUTES A CRIMINAL VIOLATION.



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EMPLOYER REFERENCE FORM FOR NURSING LICENSURE PURPOSES

SECTION A: APPLICANT INFORMATION – to be completed by applicant

Complete Section A and send to each nursing employer during the most recent six months of your nursing practice. If you graduated within the past year and have not been employed as a nurse for at least six months, send this form to your school of nursing for completion in addition to sending it to your employers. You may duplicate the form as needed.

1. Name: _____
Last First Middle

2. Address: _____
Street

City State Zip

3. Social Security Number: _____

4. Phone: _____

5. Email: _____

6. Type of Application: ☐ RN ☐ LPN ☐ APN

7. Employer/School Name: _____

8. Address: _____
Street

City State Zip

AUTHORIZATION FOR RELEASE OF INFORMATION

As an applicant for Nursing licensure in the State of Delaware, I hereby authorize release of reference information about my Nursing employment and about my Nursing education at the above named institution.

APPLICANT SIGNATURE: _____ **DATE:** _____

***The Board office will accept only forms it receives directly from the employer/school.
Forms returned by the applicant will not be accepted.
Faxed forms will not be accepted.***

SECTION B: REFERENCE – to be completed by applicant's nursing employer or nursing school

The applicant whose name appears on reverse has applied for Nursing licensure in Delaware. Please complete the appropriate box below and sign where indicated. Thank you for your assistance.

NURSING EMPLOYER

Applicant Name: _____

Name of Employer: _____

The applicant was employed as: LPN ☐ RN ☐ APN ☐

From: _____ To: _____ Currently Employed ☐
Month/Day/Year Month/Day/Year

Based on this person's performance, would you recommend her/him for licensure? Yes ☐ No ☐

If you checked no, please explain. Your answer is a factor in determining eligibility for Delaware licensure.

Name of Person Completing Form: _____ Title: _____

Signature: _____ **Date:** _____

Phone: _____ Email: _____

OR

NURSING SCHOOL

Applicant Name: _____

The applicant completed the RN ☐ or LPN ☐ educational program at:

Name of School: _____ Graduation Date: _____
Month/Day/Year

Name of Person Completing Form: _____ Title: _____

Signature: _____ **Date:** _____

Phone: _____ Email: _____

The Board office will accept only forms it receives directly from the employer/school. Mail form to

Board of Nursing
Cannon Building, Suite 203
861 Silver Lake Blvd,
Dover DE 19904

***Forms returned by the applicant will not be accepted.
Faxed forms will not be accepted.***

DELAWARE BOARD OF NURSING

VERIFICATION OF CONTINUING EDUCATION

Complete and sign this form. Enclose it with your *Application for Reinstatement*.

- **You must list your continuing education (CE) on this form *in addition to* sending the completion certificates.**
- Print or type all entries.
- List complete dates (mm/dd/yyyy) as stated on certificate, complete course names, complete names of providers (not the presenters) and number of contact hours awarded for continuing education in the chart below. Additional space is on page 2. Initials for courses and providers cannot be accepted.
- **Sign and date in the space provided.**
- **Submit a copy of the completion certificate for each course you list.**

IDENTIFYING AND CONTACT INFORMATION

Name: _____ DE Nursing License Number: _____
 Last First MI

Address: _____
 Street City State Zip

CONTINUING EDUCATION REQUIREMENT

Are you enrolled in a nursing degree program? Yes ☐ No ☐

Check one:

- ☐ I am a Licensed Practical Nurse. I and am required to submit **24** hours of continuing education.
- ☐ I am a Registered Nurse. I am required to submit **30** hours of continuing education.

DATE mm/dd/yyyy	NAME OF COURSE/PROGRAM/CONFERENCE (Do not use initials.)	PROVIDER NAME (NOT Presenter or Approver) (Do not use initials.)	CONTACT HOURS 1 college credit = 5 contact hrs

You may duplicate this page if needed.

DATE mm/dd/yyyy	NAME OF COURSE/PROGRAM/CONFERENCE (Do not use initials.)	PROVIDER NAME (NOT Presenter or Approver) (Do not use initials.)	CONTACT HOURS 1 college credit = 5 contact hrs

I certify that the information contained in this document is true and correct to the best of my knowledge.

SIGNATURE OF APPLICANT: _____ Date: _____